If continuation sheet 1 of 1

Division of Health Ca	are Facilities				FORM	APPROVE
STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	RECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BOULEVARD TERRAACE B. WING		(X3) DATE SURVEY GOMPLETED C 12/28/2011	
		DDRESS, CITY, STATE, ZIP CODE		121	20/2011	
BOULEVARD TERRAC	E REHABILITATION ANI	1530 MID	DLE TENNES ESBORO, TN	SEE BLVD		
PREFIX (EACH DE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
I N0002908	e complaint investigation # 1 conducted on 12/28/11 the by deficiencies cited.	ere were	N 002	DEFICIENCI		
ision of Health Care Facilitie	es		1	TITLE		(X6) DATE

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BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FATE FORM